DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/13/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185134	A. BUILDING _____ B. WING _____	08/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZARD NURSING HOME	390 PARK AVENUE HAZARD, KY 41702

RECEIVED
SEP 23 2010
Division of Health Care
Southern Enforcement Branch

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on August 24-26, 2010. Deficient practice was identified with the highest scope and severity cited at "E" level.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278	**(SEE ATTACHED)**	**10-6-10**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sheila K. Noe | TITLE: Administrator | (X6) DATE: 9-23-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278	Continued From page 1 Based on observation, interviews, and record reviews, it was determined the facility failed to ensure the comprehensive assessment accurately represented the resident's status for two (2) of thirty (30) sampled residents (resident #2 and resident #19). The findings include: 1. A review of the medical record of resident #2 revealed the resident had been admitted to the facility on July 8, 2008. The resident's diagnoses included Anxiety, Hypertension, and Peripheral Vascular Disease. Continued review of the medical record of resident #2 revealed facility staff had completed a significant change Minimum Data Set (MDS) on March 31, 2010, due to an increase in the resident's weight. Based on documentation on the MDS, the resident had been assessed to have no skin impairment and did not have a history of an ulcer, resolved or healed, within the previous 90 days. In addition, a review of a Resident Assessment Protocol Summary (RAPS) completed on April 1, 2010, revealed resident #2 had not been assessed to be at risk for the development of pressure sores. A review of a quarterly MDS completed on June 28, 2010, revealed resident #2 had a Stage II pressure area. A review of a plan of care developed by facility staff for resident #2 revealed the resident had "impaired skin integrity." Based on documentation on the plan of care, resident #2 had returned from a hospitalization and had been assessed to have a "blister" to the inner calf of the resident's left leg. Documentation revealed resident #2 had been hospitalized from June	F 278		

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F 278	Continued From page 2 10-19, 2010. A review of a skin assessment completed on June 19, 2010, the day of the resident's return from the hospital, revealed the resident had an "open blister" to the inner calf on the lower portion of the resident's left leg. Observation of resident #2 on August 24, 2010, at 10:25 a.m., revealed the resident's left lower leg was edematous and had an area of discoloration to the inner aspect of the leg. There were no open areas identified on the resident's left leg at the time of the observation. Interview with resident #2 on August 24, 2010, at 5:00 p.m., revealed the resident had experienced a blister to the inner aspect of the left lower leg following a hospitalization in June 2010 that had become open. The resident denied the development of a pressure sore. Interview with the MDS Coordinator on August 24, 2010, at 5:50 p.m., revealed he/she had completed the MDS assessment of resident #2 on June 28, 2010, and had documented the resident had a Stage II pressure area to the left lower leg. However, the MDS Coordinator stated the area to the resident's left lower leg had been the result of a blister that had become open, and had not been a pressure area. The MDS Coordinator stated the assessment on the MDS was not accurate and had been made due to "human error." According to the MDS Coordinator, the area on the resident's left lower leg should have been coded as other skin problems. 2. Review of the medical record revealed resident #19 was readmitted to the facility on July	F 278		

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F 278	Continued From page 3 7, 2010, with diagnoses of End Stage Renal Disease requiring Hemodialysis, Hypertension, Atrial Fibrillation, Congestive Heart Disease, and Cellulitis of the left lower extremity. Review of the Resident Assessment Protocol Summary (RAPS) dated July 20, 2010, revealed resident #19 triggered for pressure ulcer. The RAPS revealed resident #19 required treatment for two Stage II Diabetic Ulcers to bilateral legs. Review of the Comprehensive Care Plan dated July 20, 2010, revealed a care plan with interventions that directed the care for a diabetic ulcer on the right leg and a blister on the left leg. The care plan also identified a skin tear but did not specify the location. The care plan revealed resident #19 received treatment recently for cellulitis of the lower extremity. However, review of the History and Physical (H&P) from the hospital stay dated July 4, 2010, revealed no evidence of a diabetes diagnosis. The H&P revealed resident #19 had advanced peripheral vascular disease. The glucose upon admission to the hospital was recorded as 123. Review of the medication administration record revealed resident #19 did not require any medications for diabetes mellitus. Review of the admission skin assessment dated July 7, 2010, revealed resident #19 had a diabetic ulcer to the left leg. Measurements of the ulcer were not documented. Further review of the MDS revealed resident #19 had been assessed to have abrasions, bruises, and skin tears, however, the MDS failed to reveal that resident #19 had an ulcer of the right leg or a blister of the left leg.	F 278		

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F 278	Continued From page 4 Interview on August 26, 2010, at 12:45 p.m., with the MDS Coordinator revealed the nurse that admitted resident #19 and the nurse that performed the MDS assessment had resigned and were no longer employed by the facility. The MDS Coordinator revealed the MDS assessment did not reflect resident #19's skin ulcer or blister. The MDS Coordinator reviewed the medical record and could not give an explanation of the ulcer being specified as a diabetic ulcer on the RAPS and care plan. The MDS Coordinator stated the ulcer should be classified as a stasis ulcer as there was no evidence of diabetes. Additionally, the MDS Coordinator stated the ulcer and blister should have be coded on the MDS under other skin problems or lesion present (M4-c).	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide services to meet professional standards of quality for one (1) of thirty (30) sampled residents (resident #30). Observation during medication pass on August 24, 2010, revealed staff failed to follow the facility's policy and procedure for administering eye drops to resident #30. The findings include:	F 281	**(SEE ATTACHED)**	**10-6-10**

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F 281	Continued From page 5 1. Observation during medication pass on August 24, 2010, at 5:10 p.m., revealed LPN #1 administered Patanol 0.1% eye drops to resident #30. The LPN instilled one drop of Patanol to resident #30's right eye and then proceeded to administer the eye drops to the left eye without washing his/her hands or changing gloves. Interview on August 25, 2010, at 3:15 p.m., with LPN #1 revealed removing gloves, washing hands, and donning a second pair of gloves was only necessary if a resident had an eye infection and had an antibiotic eye drop/cream ordered to be administered to both eyes. Interview on August 25, 2010, at 4:30 p.m., with the Staff Development/Infection Control Nurse revealed staff should remove their gloves, wash their hands, and apply a second pair of gloves prior to administering a medication to a resident's second eye. Review of the facility's policy/procedure (not dated) related to the administration of eye drops revealed staff should wash their hands and apply new, clean gloves if administering eye drops to a resident's second eye.	F 281		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	F 465	**(SEE ATTACHED)**	**10-9-10**

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F 465	Continued From page 6 failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. A medication cart on the 200 Hall was observed to be soiled, seat cushions on resident chairs were soiled and torn, doors to resident rooms were chipped exposing splintered wood, faucets were leaking, toilet tissue dispenser bars were missing, light covers were missing, and several lights would not turn on. The findings include: Observation of the facility during the environmental tour on August 25, 2010 and August 26, 2010, revealed the following items were in need of repair/cleaning: -a medication cart on the 200 Hall was observed to have a buildup of dirt around the base and on the wheel of the cart. Additionally, tape residue was observed on the individual resident medication drawers that was blackened and soiled, -the shower curtain in the men's shower room on the 100 Hall was torn, -the wood threshold at the double door entrance to the TV/Dining Room on the 400 Hall extended upward on the left side, -the seat cushions on the dining chairs in the 400 Hall TV/Dining area were soiled and torn, and the seat cushion in resident room 126 was soiled, -the rugs at the main entrance and at the side entrance at the 400 Hall were soiled with large stains present, -bathroom light covers were missing in resident rooms 323, 410, 411, and 426, -leaky faucets were observed in the sink in resident rooms 108 and 405, in the men's and	F 465		

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F 465	Continued From page 7 women's shower on the 100 Hall, and in the shower in resident room 403, -the commode was leaking in resident room 319, -the faucet was loose in resident rooms 100, 404, and 410, -the tissue paper dispenser bar was missing in resident rooms 114, 118, 404, and 406 and in the 100 Hall women's shower room, -the tissue paper dispenser was loose from the wall in the bathroom of resident room 100, -the wood entry doors were observed to be chipped exposing splintered wood in resident rooms 101, 106, 107, 108, 110, 118, 119, 123, 126, 210, 310, 312, 315, 406, 409, 411, 414, 420, 422, 424, 426, and 427, and the double doors at the main entrance to the facility, the double fire doors at the 400 Hall, and the entrance door near the 400 whirlpool room, -the support bar at the commode in the men's shower room on the 300 Hall was loose, -a black substance was present in the grout around the edges of the shower floor in the men's shower room of the 100 Hall and 300 Hall, and in the resident shower in room 403, -the formica was chipped at the sink in resident rooms 206 and 319, -rust was observed at the shower drain in the women's 100 shower room, on the floor below the sink in the bathroom of room 113, in the bathtub in resident room 218, and at the commode base in the bathroom in room 319, -baseboard was missing in the bathroom of resident room 302, -the towel bar was loose in resident rooms 116 and 124, -a hole was observed in the wall in resident room 116, -dust tags were observed hanging from the ceiling in resident bathrooms 410 and 425,	F 465		

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F 465	Continued From page 8 -the emergency call light in the bathroom of resident room 109 had an exposed sharp area where the string was attached, and the emergency call bell plate was loose from the wall in resident room 323, -lights would not turn on in the bathroom in resident rooms 120, 214, and 419, -holes were present in the bathroom doors in resident rooms 407, 410, and 411, and in the closet doors in resident rooms 403 and 419, -the wallpaper near the fire door leading to the 100 Hall was peeling, -the fall mats in resident rooms 210, 323, and 423 had torn edges exposing the padding, -the electrical outlet near the air conditioner in resident room 423 was loose from the wall, -a crack was observed in the ceiling in the bathroom of resident room 310, -the ring of the doorknob was loose in resident room 422, -the water fountain near resident room 113 had a buildup of an unknown white substance, mineral deposits, and rust at the drains, -the floor tiles in the bathroom of resident room 315 were stained, -broken floor tiles were observed near the air conditioner in resident room 214, -the porcelain of the sink in resident room 401 was cracked and a loud noise was produced when the hot water was turned on, -a dried white and brownish substance was observed on the air conditioner in resident room 405, -the drywall was marred/scraped near the closet in resident room 419, -black scratches were observed on the commode seat in the men's shower room on the 400 Hall and the baseboard was loose from the wall near the commode.	F 465		

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F 465	Continued From page 9 Interview on August 26, 2010, at 2:45 p.m., with the Maintenance Supervisor (MS) revealed maintenance request sheets were kept at the nurses' stations and staff was required to complete the request form to inform the Maintenance Department of any items in need of repair. The MS stated staff could also call the front office and report any items in need of repair. The MS stated the MS had an assistant, but regular rounds could only be conducted once every two weeks to look for items in need of repair. The MS stated any sharp or jagged edges on the doors and floor mats could cause skin tears or injury to the residents.	F 465		
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide timely laboratory services to meet the needs of one (1) of thirty (30) sampled residents. Resident #17 had physician's orders for a hemoglobin A1C to be obtained every three (3) months. However, there was no evidence the laboratory test was obtained since April 6, 2010, until the facility was made aware and a stat HGBA1C (blood test that checks for long term blood sugar control) was obtained on August 25, 2010. The findings include:	F 502	**(SEE ATTACHED)**	**10-6-10**

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F 502	Continued From page 10 A review of the medical record for resident #17 on August 25, 2010, revealed diagnoses that included Diabetes, Hypertension, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Alzheimer's, and Cancer of the Lungs with Metastasis to the Bones. Further review of the medical record revealed physician's orders for HGBA1C to be obtained every three (3) months. The latest HGBA1C was obtained on April 6, 2010. There was no evidence a HGBA1C test was obtained until the facility was made aware on August 25, 2010. The facility obtained a stat HGBA1C on August 25, 2010, with the results being 7.9 (normal result 4.8-6.0). An interview with the Director of Nursing (DON) on August 25, 2010, at 3:40 p.m., revealed the Supervisors for each unit completed a laboratory calendar for the month with the resident's name, and the routine lab tests that were required for the resident. The supervisors completed lab requisitions for the required lab tests and sent them to the facility lab. The facility lab drew the required lab tests according to the calendar the facility completed. The lab sent the results of the laboratory tests via fax to the facility. The facility then contacted the physician with the results from the lab tests. The DON stated the stapled requisition form had multiple copies and the supervisor faxed results of the lab to the requisition form. The DON further stated the consulting pharmacist reviewed the medical records every month for lab results to ensure the lab was conducted. The DON stated the HGBA1C test for resident #17 was missed for the July blood draw.	F 502		

Hazard Nursing Home, Inc.
Annual Survey August 24-26, 2010
Plan of Correction

F278

1. The Quarterly Review Assessment dated 6-28-10 for Resident #2 was modified to address the resident's blister to left lower leg under other skin problems and is no longer identified as a pressure ulcer. Resident #19's 07-20-2010 Admission/14d Assessment and RAP's were modified to address the ulcer to the right leg and blister to the left leg. The resident's care plan was corrected to address the area on the right leg as a stasis ulcer and address the area to the left leg as a blister.

2. All residents have been reviewed by the Unit Supervisors and MDS Coordinators to ensure that skin problems are assessed correctly and coded appropriately on their MDS assessments/RAPs and that care plans address skin ulcers appropriately.

3. MDS Coordinators were in-serviced on September 27, 2010 by a Corporate representative regarding proper assessment of skin ulcers and coding of Section M. on the MDS.

4. The CQI Committee designee will review 2 charts of resident's with skin ulcers on each unit weekly for one month then monthly for one quarter to ensure that skin ulcers have been assessed correctly and coded appropriately on the MDS/RAP and care plan. Any irregularities will be corrected immediately and reported to the CQI Committee for further follow up.

5. Completion: 10-06-10

Hazard Nursing Home, Inc.
Annual Survey August 24-26, 2010
Plan of Correction

F281

1. Resident #30 is receiving eye drops as ordered following professional standards. Nurses are removing gloves and washing hands and donning new gloves after administering eye drops for one eye prior to administering drops in the other eye for those residents that are receiving eye drops for both eyes.

2. All residents are receiving their eye drops as ordered. Nursing staff are following appropriate professional standards regarding changing of gloves and washing hands and donning new gloves when eye drops are ordered for both eyes.

3. The Policy for Administration of Eye Drops/Eye Ointments was updated on 08-25-2010 to address washing hands and changing gloves when administering medication to both eyes. Nurses/Medication Aides on duty were immediately in-serviced on the new policy. All Nurses and Medication Aides were in-serviced on September 29, 2010 by the DON and Unit Supervisors regarding the Policy for Administering Eye Drops/Eye Ointments.

4. A CQI Committee designee will observe 1 nurse administering medications per unit per week for one month, then monthly for one quarter then annually thereafter during medication audits. These audits will specifically focus on administration of eye medication. Any irregularities will be corrected immediately and forwarded to the CQI Committee for further follow up.

5. Completion: 10-06-10

Hazard Nursing Home, Inc.
Annual Survey August 24-26, 2010
Plan of Correction

F 465

1. All items and areas in need of repair have been repaired or replaced when indicated. 200 Medication cart has been cleaned. 400 Dining Room/TV Room chairs have been re-covered. Resident room chairs are being replaced as indicated. Rugs to main entrance and at side entrance of 400 unit have been cleaned/replaced as indicated. Fall mats in resident rooms were replaced as indicated. Shower curtains, bathroom light covers, tissue paper dispenser bars, bathroom support bars, baseboard, towel bars, doorknob rings have been replaced as indicated. Doors, 400 Hall door threshold, faucets, commodes, tile, wallpaper, Formica, holes, emergency call light and plates, lights, electrical outlets, drywall and cracks have been repaired. The black substance present in the grout around the edges of the shower floor in men's shower room of the 100 hall and 300 hall and in resident shower room in 403 has been cleaned. Drains have been replaced or rust removed. Dust tags from ceiling were removed/cleaned. Air conditioners, water fountains, and floor tiles have been cleaned as indicated. The Corporate Maintenance Foreman/Consultant, Maintenance Supervisor and Housekeeping Supervisor have made observations of all concerns listed on the 2567. They have verified correction of all identified concerns.

2. All resident areas are safe, functional and sanitary. Thorough environmental rounds have been conducted throughout the facility by the Corporate Maintenance Foreman/Consultant, Maintenance Supervisor and the Housekeeping Supervisor and identified concerns have been corrected.

3. An in-service was conducted on September 29, 2010 by the DON and/or Administrator with all staff including housekeeping and maintenance staff regarding the importance of maintaining a safe, functional, sanitary and functional environment. The in-service specifically addressed reporting items in need of repair/replacement to the Maintenance Department utilizing the CQI referral form or Maintenance Repair Request Form. Additional in-services were conducted with housekeeping staff on September 29, 2010 by the Housekeeping Supervisor regarding maintaining a safe, clean, sanitary environment. Additional in-services were conducted with maintenance staff on September 27, 2010 by the Maintenance Foreman regarding maintaining a safe, functional, and sanitary environment. This in-service also included a review of the Preventative Maintenance Log Sheet to ensure equipment, rooms, tile, lights, chairs, doors etc. are periodically checked for proper functioning, are in safe working order, and pose no danger to residents and the importance of prompt response to repair requests.

4. CQI Committee designees will conduct thorough walking rounds on a weekly basis for one month, then monthly for one quarter, then monthly thereafter to observe for items in need of repair or replacement or areas in need of cleaning. These rounds will focus on resident care areas as well as common areas and shower rooms. Any irregularities will be corrected immediately and reported to the CQI Committee for further follow-up and review.

5. Completion:10-09-10

Hazard Nursing Home, Inc.
Annual Survey August 24-26, 2010
Plan of Correction

F 502

1. Resident #17's physician was notified of the missed lab and a Hemoglobin A1C was obtained.

2. A lab audit was done on all residents' charts to ensure that labs had been obtained as scheduled per physician's orders. Any identified concerns were addressed and corrected.

3. Unit Supervisors were in-serviced on September 27,2010 by the DON regarding the proper procedure for completing Monthly Lab Calendars and the importance of accuracy of these calendars. At the end of each month Unit Supervisors will obtain a listing of all current lab orders and will schedule these tests accordingly on Lab Calendar. Lab requisitions will be completed and labs will be drawn per schedule. Labs will be reconciled on a daily basis per Unit Supervisors or the Staff Development Coordinator or Assistant DON in their absence. Additionally the lab will do chart audits q 2 months to ensure labs have been drawn per physician's orders.

4. The CQI Committee designee will review 2 charts per unit weekly for one month, then monthly for one quarter. These reviews will consist of checking current lab orders and ensuring that labs were obtained timely and are filed on the resident chart. Any irregularities will be corrected immediately and forwarded to the CQI Committee for further follow up.

5. Completion: 10-06-10